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SENATE BILL 305
By Fowler

AN ACT to amend Tennessee Code Annotated, Title 4; Title 33; Title 48; Title 56 and Title 71, to enact the "Tennessee Managed Care Medicaid Reform, Children's Insurance Program and Tennpool Act".

WHEREAS, the program currently known as TennCare has provided as part of a federal-state Medicaid demonstration program, an opportunity for more than five hundred thousand (500,000) persons who were previously uninsured or uninsurable to participate in a managed care health program; and

WHEREAS, the TennCare program provided Tennessee and other states with an opportunity to experiment in new approaches to providing health care to its citizens; and

WHEREAS, subsequent federal programs, such as the "State Children's Health Insurance Program" of the "Balanced Budget Act of 1997," Pub. Law 105-33, have provided Tennessee with additional resources and approaches to health care; and

WHEREAS, modifications to the TennCare program are desirable to bridge between federal entitlement programs, such as Medicaid and TennCare, and private insurance programs; now, therefore,

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. This Act shall be known and may be cited as the "Tennessee Health Care Reform, Children's Insurance Program and Tennpool Act."

PART 1 -- MANAGED CARE MEDICAL ASSISTANCE

SECTION 2. Tennessee Code Annotated, Title 71, Chapter 5, Part 1, is amended by adding the following Sections 3 through 10 as new, appropriately designated sections:

SECTION 3. Sections 3 through 10 may be known and cited as the Tennessee Managed Care Medical Assistance program.

SECTION 4. The purpose of this Section 3 through 10 is to make possible managed care medical assistance to those recipients determined to be eligible under this chapter to receive medical assistance that conforms to the requirements of title XIX of the Social Security Act and the regulations promulgated pursuant thereto including modifications made by the "Balanced Budget Act of 1997", Pub. Law No. 105-33. Medical assistance pursuant to this act may also be provided pursuant to any federal waiver received by the state that waives any or all of the provisions of title XIX or pursuant to any other applicable federal law to the extent adopted by means of an amendment to the required title XIX state plan. The commissioner shall be authorized to promulgate necessary rules under Title 4, Chapter 5, including public necessity rules to meet the time-frame of this part.

SECTION 5. (a) The commissioner of health, in conjunction with the commissioner of finance and administration is directed to develop and provide a Tennessee medicaid program that consists of a mandatory managed care program consistent with the "Balanced Budget Act of 1997", Pub. Law 105-33 and in accordance with the provisions of this part. The commissioner shall develop an orderly transition plan for those enrollees in the TennCare program who qualify as medicaid enrollees under this part. Transition plans shall also be developed for those children who no longer qualify for services under this part but who qualify under the Children's Insurance Program under this act and those adults and children who no longer qualify for medicaid under this part but who qualify for the Tennpool program under this act.

(b) Transition plans shall be developed in a manner to provide continuity of care for those persons who continue to qualify for any services under this act. Transition plans shall be implemented within ninety (90) days of the effective date of this act.

SECTION 6. (a) Medicaid services under this part shall be provided through two (2) or more entities licensed as health maintenance organizations under Title 56, Chapter 32 and certified as risk-bearing entities, that meet the federal definition of managed care entities under 42 U.S.C. § 1396 u-2(a) and any regulations promulgated thereto. Such managed care entities shall contract with a reasonable and adequate network of health care providers to render health care services consistent with this part. The department shall contract with such managed care entities as appropriate to implement this part.

(b) The commissioner is authorized to establish by rule procedures for access to services to individuals exempt from mandatory enrollment in a managed care entity pursuant to 42 U.S.C. § 1396 u-2(a).

(c) The commissioner shall permit an individual to choose a managed care entity from not less than two (2) such entities that meet the applicable requirements of this part. An individual enrolled with a managed care entity shall be permitted to terminate or change such enrollment:

(1) for cause at any time, and

(2) without cause

(A) during the 90-day period beginning on the date the individual receives notice of enrollment, and

(B) at least every twelve (12) months thereafter.

Each enrollee shall be provided with notice of the right to change or terminate enrollment.

(d) The commissioner shall establish a default enrollment process consistent with 42 U.S.C. § 1396 u-2.

SECTION 7. The commissioner shall, by rule and through contract, require participating managed care entities to perform the following functions:

(1) Provide easily understandable enrollment notices, information and instructional materials;

(2) Make available to enrollees and potential enrollees in the entity's organizational area information regarding:

(A) the identity, locations, qualifications and availability of providers who participate with the entity;

(B) provide information about the rights and responsibilities of the enrollees under the medicaid managed care plan;

(C) inform enrollees of the grievance and appeals procedures available to an enrollee and a health care provider to challenge or appeal the failure of the entity to cover a service;

(D) inform enrollees about all items and services that are available under the managed care medicaid contract between the state and the entity that are covered either directly or indirectly through referral and prior authorization;

(E) provide comparative information annually to enrollees relating to benefits and cost-sharing, service area and quality and performance.

SECTION 8. The commissioner shall require by rule and through contract that each entity, to the extent required by 42 U.S.C. § 1396 u-2(b):

(1) provide coverage for emergency services;

(2) protect enrollee provider communications;

(3) establish and comply with an internal grievance procedure;

(4) demonstrate adequacy of capacity and services;

(5) protect enrollees against liability for payment;

(6) not discriminate against providers as to participation, reimbursement or indemnification; and

(7) comply with requirements of federal law regarding maternity and mental health.

SECTION 9. The commissioner shall establish and maintain a quality assessment and improvement strategy consistent with 42 U.S.C § 1396 u-2(c). Each contract with a managed care entity shall provide for an annual external independent review as required by 42 U.S.C. § 1396 u-2(c).

SECTION 10. (a) The commissioner shall establish and maintain the fraud and abuse, marketing, conflict of interest and physician identifier protections required by 42 U.S.C. § 1396 u-2(d).

(b) The commissioner shall establish a system of intermediate sanctions and temporary management, contract provision protections and prompt pay requirements, consistent with 42 U.S.C. § 1396 u-2(e) and (f), and require disclosures pursuant to 42 U.S.C.§ 132 a-3.

SECTION 11. Tennessee Code Annotated, Section 71-5-103, is amended by adding the following as a new item:

( ) "Managed care entity" means an entity licensed as a health maintenance organization under Title 56, Chapter 32, and certified by the state as a risk-bearing entity, that meets the federal requirements of 42 U.S.C. § 1396 u-2(a) and regulations promulgated thereto.

SECTION 12. Tennessee Code Annotated, Section 71-5-101, is deleted.

SECTION 13. Tennessee Code Annotated, Section 71-5-102, is deleted.

SECTION 14. Tennessee Code Annotated, Section 71-5-103, is amended by deleting the last sentence of item (5) that begins with the words "To the extent".

SECTION 15. Tennessee Code Annotated, Section 71-5-106(k), is deleted, and the following is added:

(k) Children eligible for coverage under the Children's Health Insurance Program, 42 U.S.C. §1397aa, shall be provided assistance pursuant to Part 2 of this act.

SECTION 16. Tennessee Code Annotated, Section 71-5-110, is deleted.

SECTION 17. Tennessee Code Annotated, Section 71-5-117(f), is deleted and the following is substituted instead:

The state's right to action shall include recovery for programs included in the "Tennessee Health Care Reform, Children's Insurance Program and Tennpool Act of 2000".

SECTION 18. Tennessee Code Annotated, Sections 71-5-118, 71-5-122 and 71-5-123, are amended by adding the words "or managed care entities" after the word "vendor" or "vendors" any time it may appear.

SECTION 19. Tennessee Code Annotated, Section 71-5-128, is deleted.

SECTION 20. Tennessee Code Annotated, Section 71-5-137, is amended by deleting the words "managed care organization" and by substituting the words "managed care entity" each place it may appear.

SECTION 21. Tennessee Code Annotated, Section 71-5-137, is further amended by deleting the word "TennCare" and substituting instead the words "managed care medicaid program" each place it may appear.

SECTION 22. Tennessee Code Annotated, Section 71-5-181, is amended by deleting subsection (b) and by appropriately renumbering remaining subsections.

SECTION 23. Tennessee Code Annotated, Section 71-5-188, is amended by deleting the word "TennCare" and by substituting instead the words "managed care medicaid program."

SECTION 24. Tennessee Code Annotated, Section 71-5-189, is amended by deleting the words "of TennCare" and by adding the word "medicaid" before the word "bureau."

PART 2 -- TENNESSEE CHILDREN'S HEALTH INSURANCE ACT

SECTION 25. Tennessee Code Annotated, Title 71, Chapter 5, is amended by adding Sections 26 through 32 as a new part.

SECTION 26. This part may be known and cited as the "Tennessee Children's Health Insurance Program Act".

SECTION 27. (a) The purpose of this part is to create a program to provide health care benefits to children who are not eligible for health care services under the Tennessee medicaid program under this act. These health care services may be provided by the payment for health care through an insurance plan or through another entity that meets the requirements of this part.

(b) As used in this part, "program" means the state children's health insurance program.

(c) Within the limits of specific appropriations provided in the annual appropriations act, the department of health shall establish, administer, and monitor a program to provide health care to uninsured children. The department shall not use money appropriated for this program to expand eligibility criteria for the Tennessee medicaid program. This program shall conform to the requirements of the federal "State Children's Health Insurance Program" of the "Balanced Budget Act of 1997", Pub. Law 105-33, and regulations promulgated pursuant to such act.

(d) The department is directed to develop a transition plan for children covered by the TennCare program who were eligible solely as uninsured or uninsurable. Such transition plan shall be implemented within ninety (90) days of the effective date of this act. Children who are eligible under this part shall be transitioned from TennCare in a manner to foster continuity of care. Children not eligible under this part or under the Tennessee medicaid program may, if eligible, enroll in the Tennpool program under Part 3 of this act.

SECTION 28. (a) To be considered eligible for the program, a child:

(1) must be nineteen (19) years of age or younger;

(2) except as provided in subdivision (4), must have a combined family income at or below two hundred percent (200%) of the federal poverty level;

(3) may not already be covered by private insurance that offers creditable coverage, as defined in 42 U.S.C. 300gg(c);

(4) may not be eligible for medicaid benefits under this act; and

(5) must be a United States citizen or qualified alien and a Tennessee resident.

(b) The department of health shall adopt rules that establish the program's criteria for residency. The criteria shall conform as nearly as practicable with the residency requirements for medicaid eligibility.

(c) Subject to the provisions of this part, rules governing eligibility may also include financial standards and criteria for income and resources, treatment of resources, and nonfinancial criteria.

(d) If the department determines that there is insufficient funding for the program, it may lower the percentage of the federal poverty level established in subsection (a)(2) of this section in order to reduce the number of persons who may be eligible to participate.

SECTION 29. (a) Benefits provided to participants in the program include, but are not limited to:

(1) inpatient and outpatient hospital services;

(2) physician's surgical and medical services;

(3) laboratory and x-ray services;

(4) well-child and well-baby services;

(5) immunizations;

(6) clinic services;

(7) dental services;

(8) prescription drugs;

(9) mental health services;

(10) hearing and vision exams; and

(11) eyeglasses.

SECTION 30. (a) The department of health may contract with insurance companies or other entities to provide services for a set monthly or yearly fee based on the number of participants in the program and the types of services provided.

(b) The child health assistance provided under this part shall consist of whichever of the following is most economical:

(1) Health benefits coverage that is equivalent to the benefits coverage of the benchmark benefit packages in subsection (c) of this section.

(2) Health benefits coverage that meets each of the three (3) following:

(A) The coverage includes benefits for items and services within each of the following categories:

(i) inpatient and outpatient hospital services;

(ii) physicians' surgical and medical services;

(iii) laboratory and x-ray services; and

(iv) well-baby and well-child care, including age appropriate immunizations.

(B) The coverage as an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark packages in subsection (c) of this section; and

(C) With respect to the following services, for which coverage is provided under the benchmark package used under subsection (c), the coverage has an actuarial value that is equal to at least seventy-five percent (75%) of the actuarial value of the coverage of that category in such package:

(i) coverage of prescription drugs;

(ii) mental health services;

(iii) vision services; and

(iv) hearing services.

(3) Any other health benefit coverage approved by the Secretary of Health and Human Services.

(c) The benchmark benefit packages are as follows:

(1) The standard Blue Cross/Blue Shield preferred option as described in 42 U.S.C. § 1397cc(b)(1);

(2) A health benefits coverage plan available to state employees;

(3) A health benefits coverage plan through a health maintenance organization as described in 42 U.S.C. § 1397cc(b)(3).

SECTION 31. (a) The department of health may charge fees to participants in the program. The fees may include:

(1) monthly or yearly enrollment fees;

(2) deductible or minimum charges to be incurred or spent before benefits are paid;

(3) cost-sharing for individual benefits; and

(4) other types of charges assessed as part of the program and consistent with 42 U.S.C. § 1397cc.

SECTION 32. (a) The department of health shall adopt rules necessary for the administration of the program, including rules governing the application process, termination, and confidentiality.

(b) The rules shall include, as necessary:

(1) the amount, scope, and duration of specific services provided;

(2) criteria to ensure that the services provided are medically necessary and cost-effective;

(3) provisions for participant cost-sharing, including, at the department's discretion:

(A) the establishment of enrollment fees, premiums, deductibles, and copayments consistent with this part;

(B) the process for setting the amounts of enrollment fees, premiums, deductibles, and copayments, taking into account a participant's family income and resources; and

(4) the type of professional who may deliver services or direct the delivery of services and the qualifications required of those professionals.

(c) In adopting rules, the department shall consider the federal requirements that may not include any provision that places that funding at risk.

(d) Rules adopted by the department pursuant to this part may be promulgated as public necessity rules.

PART 3 -- TENNPOOL

SECTION 33. Tennessee Code Annotated, Title 71, Chapter 5, is amended by adding Sections 34 through 44 as a new part.

SECTION 34. This part may be known and cited as the "Tennpool Act of 2000".

SECTION 35. As used in this part, unless the context requires otherwise:

(1) "Agency" means the state agency selected to administer the plan.

(2) "Uninsurable" means a person who is unable to purchase health insurance due to an existing medical condition, who is not otherwise eligible for medical assistance under this act or Tennessee Code Annotated, Title 71, Chapter 5, and who otherwise meets the eligibility requirements for Tennpool. The commissioner of commerce and insurance shall develop rules to make ineligible those individuals who for the purpose of becoming eligible for Tennpool do not enroll in employer sponsored health insurance plans in a timely fashion and thereby become uninsured with respect to such plan. To the extent the commissioner of commerce and insurance, with the approval of the commissioner of finance and administration, determines it is cost effective, uninsurable

may also include a person who has some insurance coverage but whose coverage excludes or waives preexisting conditions if such person otherwise meets the eligibility requirements for Tennpool.

(3) "Uninsured" means a person who does not have coverage under an individual or family health insurance policy, and access to (i) an employer-sponsored health insurance plan, or (ii) to another government plan, or who is not otherwise eligible for medical assistance under this act or Tennessee Code Annotated, Title 71, Chapter 5, and who otherwise meets the eligibility requirements for Tennpool.

SECTION 36. The commissioner of finance and administration is directed to develop a program to provide a managed care health insurance plan for uninsurable and uninsured residents of this state over eighteen (18) years of age in accordance with the provisions of this act within ninety (90) days of the effective date of this act. If appropriate, such plan shall be submitted to the federal department of health and human services as a waiver. The plan shall not take effect until the governor certifies that either a state plan or a joint federal-state waiver for a managed care health insurance plan for uninsurable and uninsured residents of this state is ready for implementation. The plan may set a maximum limit on the number of enrollees who may be on the program at any one time.

SECTION 37. The managed care health insurance plan for uninsurable and uninsured residents of this state shall be a state-funded and operated plan or may be submitted to the federal department of health and human services as a waiver concerning the medical assistance program operated under Tennessee Code Annotated, Title 71, Chapter 5, or as a modification of an existing waiver. For the coverage of uninsured and uninsurable residents of this state the plan shall develop a benefits package the value of which is no greater than the most basic managed care health plan offered to state employees or such benefits package as is approved by the federal department of health and human services as a part of a federal waiver. The managed care portion of the program shall utilize one or more entities licensed to

administer health maintenance or insurance plans under Tennessee Code Annotated, Title 56, to contract with a reasonable network of health care providers to render health care services to the uninsured and the uninsurable. The program shall provide for an administrative services only contract for such entity or entities. The program may provide for contracting with appropriate entities for any administrative service or function and, if appropriate, such contracting may be on a statewide or regional basis. The commissioner of finance and administration in consultation with the commissioner of commerce and insurance shall develop and publish a request for proposal for administration of all or any part of the Tennpool program. Other state agencies as appropriate shall provide assistance to the administering entity. The state shall contract with the managed care entity or entities as appropriate to implement the provisions of this act.

SECTION 38. (a) The Tennpool program shall be funded with state funds, premiums from enrollees and, if applicable, federal financial participation.

(b) State funds shall be set in the general appropriations act each year but such funds shall not be less than the amount of state funds paid to managed care organizations in the fiscal year 2000-2001 state budget.

(c) Premiums, co-payments and other cost sharing from enrollees shall be as determined in Section 40.

(d) Federal financial participation, if applicable, shall be as set in a waiver or modification of an existing federal waiver for medical assistance.

(e) Following the close of each fiscal year, the commissioner of finance and administration shall prepare a report analyzing the Tennpool's projected revenues and expenditures and funding requirements. The commissioner shall present this report to the general assembly and the governor with a recommendation for the funding of the program.

SECTION 39. A Tennpool fund shall be established as a separate account in the state treasury. Moneys in the Tennpool fund, including interest earned on such moneys, shall be

invested by the state treasurer pursuant to Tennessee Code Annotated, Sections 9-4-602 and 9-4-603 for the sole benefit of the fund. Any moneys remaining in the Tennpool fund at the end of any fiscal year shall not revert to the general fund, but shall remain available for use by the fund.

SECTION 40. (a)

(1) The agency will require enrollees to pay premiums to the state for coverage under the program. The monthly premium scale shall be set in accordance with subdivision (2) and co-payments and other cost-sharing shall be set in accordance with the tables contained in subsection (b). Subject to the need for actuarial soundness, the premiums shall increase or decrease annually based on the average increase or decrease in premiums for the next fiscal year authorized by the commissioner of commerce and insurance for all managed care health insurance plans regulated by the department of commerce and insurance for which there were not less than seventy-five (75) participants nor more than one hundred fifty (150) participants and for which co-payments or other cost-sharing are comparable to those required by Tennpool.

(2) The premium scale initially adopted on the date this act becomes a law shall be as follows:

(A) Uninsurable

Income Level	Premiums	
% of Poverty	Individual	Family
0 – 199	$ 50	$ 100
200 – 249	$ 100	$ 250
250 – 299	$ 150	$ 375
300 – 349	$ 200	$ 500
350 – 399	$ 200	$ 500
400 – 499	$ 200	$ 500
500 – 599	$ 200	$ 500
600 – 699	$ 250	$ 625
700 – 749	$ 250	$ 625
750 – 799	$ 250	$ 625
800 - over	$ 250	$ 625

(B) Uninsured (enrolled in TennCare on the effective date of this act)

Income Level	Premiums	
% of Poverty	Individual	Family
0 – 199	$ 50	$ 100
200 – 249	$ 100	$ 250
250 – 299	$ 150	$ 375
300 – 349	$ 200	$ 500
350 – 399	$ 200	$ 500
400 – 499	$ 200	$ 500
500 – 599	$ 200	$ 500
600 – 699	$ 250	$ 625
700 – 749	$ 250	$ 625
750 – 799	$ 250	$ 625
800 - over	$ 250	$ 625

(C) Uninsured (enrolled under TennPool)

Income Level	Premiums	
% of Poverty	Individual	Family
0 – 249	$ 100	$ 250
250 – 299	$ 150	$ 375
300 – 349	$ 200	$ 500
350 – 399	$ 200	$ 500
400 – 499	$ 200	$ 500
500 – 599	$ 200	$ 500
600 – 699	$ 250	$ 625
700 – 749	$ 250	$ 625
750 – 799	$ 250	$ 625
800 – over	$ 250	$ 625

(b)(1) Uninsurable

Income Level	Cost Sharing			
% of Poverty	OVC Co-Pay	Rx-Brand	Rx-Generic	ER Co-pay
0 – 199	$ 10	$ 10	$ 5	$ 15
200 – 249	$ 10	$ 15	$ 10	$ 15
250 – 299	$ 10	$ 15	$ 10	$ 15
300 – 349	$ 10	$ 15	$ 10	$ 15
350 – 399	$ 10	$ 15	$ 10	$ 15
400 – 499	$ 10	$ 20	$ 10	$ 15
500 – 599	$ 15	$ 20	$ 10	$ 25
600 – 699	$ 15	$ 20	$ 10	$ 25
700 – 749	$ 15	$ 20	$ 10	$ 25
750 – 799	$ 20	$ 25	$ 10	$ 50
800 - over	$ 20	$ 25	$ 10	$ 50

(2) Uninsured (enrolled in TennCare on the effective date of this act)

Income Level	Cost Sharing			
% of Poverty	OVC Co-Pay	Rx-Brand	Rx-Generic	ER Co-pay
0 – 199	$ 10	$ 10	$ 5	$ 15
200 – 249	$ 10	$ 15	$ 10	$ 15
250 – 299	$ 10	$ 15	$ 10	$ 15
300 – 349	$ 10	$ 15	$ 10	$ 15
350 – 399	$ 10	$ 15	$ 10	$ 15
400 – 499	$ 15	$ 20	$ 10	$ 25
500 – 599	$ 15	$ 20	$ 10	$ 25
600 – 699	$ 15	$ 20	$ 10	$ 25
700 – 749	$ 15	$ 20	$ 10	$ 25
750 – 799	$ 20	$ 25	$ 10	$ 50
800 - over	$ 20	$ 25	$ 10	$ 50

(3) Uninsured (enrolled under TennPool)

Income Level	Cost Sharing			
% of Poverty	OVC Co-Pay	Rx-Brand	Rx-Generic	ER Co-pay
0 – 199	$ 10	$ 10	$ 5	$ 15
200 – 249	$ 10	$ 15	$ 10	$ 15
250 – 299	$ 10	$ 15	$ 10	$ 15
300 – 349	$ 10	$ 15	$ 10	$ 15
350 – 399	$ 10	$ 15	$ 10	$ 15
400 – 499	$ 15	$ 20	$ 10	$ 25
500 – 599	$ 15	$ 20	$ 10	$ 25
600 – 699	$ 15	$ 20	$ 10	$ 25
700 – 749	$ 15	$ 20	$ 10	$ 25
750 – 799	$ 20	$ 25	$ 10	$ 50
800 - over	$ 20	$ 25	$ 10	$ 50

SECTION 41. (a) Uninsured or uninsurable residents of this state may apply to enroll in Tennpool in a manner and on such forms as the agency promulgates by rule. The commissioner shall develop a plan for the orderly application and enrollment of those constantly enrolled in TennCare. Application is for a twelve (12) month period and coverage lapses at the end of every twelve (12) month period unless the enrollee completes a reapplication process in accordance with the procedures required for an initial application. Enrollees must submit renewal applications at least thirty (30) days prior to the end of the current twelve (12) month coverage period and a renewal application may not be submitted sooner than sixty (60) days prior to the end of the current twelve (12) month period. In cases where a renewal application

has not been submitted in a timely manner, coverage shall terminate at the end of any twelve (12) month period.

(b) Uninsurable residents need not re-establish uninsurability during any consecutive re-enrollment. Uninsurability must be established if there is any break in coverage.

(c) To the extent permitted by federal law, with respect to uninsurable residents not enrolled in TennCare at the time this act becomes law, coverage for uninsurable conditions shall not attach until after three (3) months of coverage.

(d) Individuals and families enrolled in Tennpool shall remain in the program for the full twelve (12) month period unless the enrollee submits proof of coverage by a private insurer or has moved outside of the state. Premiums may be adjusted during any twelve (12) month period upon submission of proof of a change in income or change in coverage status. If coverage terminates for any reason, the terminated individual shall not be eligible for coverage for a period of three (3) months from the date coverage terminated.

SECTION 42. It shall be a Class A misdemeanor for an enrollee in the plan to fail to notify the state of any change in employment, regular income or residency within thirty (30) days of such change.

SECTION 43. It is the intent of this part that Tennpool shall be the last payor of benefits whenever any other benefit is available. Coverage under Tennpool is in excess of and may not duplicate coverage under any other form of health insurance.

SECTION 44. The commissioner of finance and administration is directed to take any action necessary to obtain the reinstitution of disproportionate share adjustments to the state under the medical assistance program from the federal department of health and human services.

SECTION 45. To the extent the provisions of this act reduce the need for staff and other supports at the bureau of TennCare, or its successor, then the commissioner of finance

and administration in consultation with the commissioner of personnel shall develop a plan for securing the appropriate reductions in staff and other supports in accordance with law.

SECTION 46. Tennessee Code Annotated, Section 71-5-135, is deleted.

SECTION 47. The commissioner of finance and administration and the agency are authorized to promulgate rules and regulations to effectuate the purposes of this act. All such rules and regulations shall be promulgated in accordance with the provisions of Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 48. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 49. This act shall take effect upon becoming law for the purposes of promulgating rules and regulations, and upon July 1, 2001 for all other purposes, the public welfare requiring it.